DEPARTMENT OF SOCIAL SERVICES
DIVISION OF MEDICAL SERVICES
700 Governors Drive
Pierre, South Dakota 57501-2291
(605) 773-3495
FAX (605) 773-5246
medical@state.sd.us
www.state.sd.us/social/medical/provider

Instate Provider Enrollment Application

Date:_____

To enroll in the South Dakota Medical Assistance Program as a Medicaid provider, this application must be completed. It contains questions to be answered completely and indicates other required documentation which must be submitted with enrollment forms.

Provider Name:_____

Facility Name:_____

Please check all that apply: _____**New Enrollment**

_____**Reinstate** _____**Reinstate Date**

_____**Federal Tax ID Number Change**

1. What is your Medicare number?_____
2. What is your National Provider Identification Number (NPI)?

   Individual NPI_____

   Individual Sub NPI_____

   Other NPI_____Address Location_____

   Other NPI_____Address Location_____
3. List all Taxonomy Codes associated with enrolling provider.

   _____

   _____
4. What is the Federal Tax Identification Name and Number (TIN) used for billing purposes?

   _____
5. What is your provider type and specialty (i.e. physician, internal medicine / hospital, psychiatric)?

   _____
6. Where will the medical services be provided (i.e. hospital, clinic, school, rehab facility)?

   _____
7. Are you employed or under contract by this facility type? _____YES _____NO

   (attach copy of contract - i.e. CRNA's & physical therapists)
8. Do you repackage for unit dose for Long Term Care recipients (for pharmacy providers only)?

   _____YES _____NO
9. What is your NCPDP Number (for pharmacy providers only)?_____
10. What is your CLIA number (for laboratories only)?_____

11. Do you wish to participate as a Primary Care Provider in the South Dakota Medical Assistance Program? _____YES _____NO If so, an Addendum to the contractual Provider Agreement must be completed. Contact our office for more information or visit our web site as noted on Page 1.

12 What is the service location name, address, and phone number?

Name:_____

Address:_____

City-State-Zip:_____

Phone Number:_____

Fax Number:_____

Contact Person:_____E-mail_____

13. What is the "pay to" location (address where payment will be sent)?

Name:_____

Address:_____

City-State-Zip:_____

Phone Number:_____

Fax Number:_____

Contact Person:_____E-mail_____

14. What is the billing location? Will you bill/process claims for enrolling provider? _____

Name:_____

Address:_____

City-State-Zip:_____

Phone Number:_____

Fax Number:_____

Contact Person:_____E-mail_____

15. When does billing location fiscal year end?_____

Also enclosed is the *South Dakota Medical Assistance Program Provider Agreement*. Please complete, sign, and return the agreement and this application along with requested information/documentation to:

Provider Enrollment
Department of Social Services
Division of Medical Services
700 Governors Drive
Pierre, South Dakota 57501-2291

<u>Please enclose a copy of all current licensure applicable showing expiration date and current W-9 (revised 11-2005)</u>. If the agreement is for an individual, that person needs to sign as 'Authorized Signature'. If the agreement is for a facility, the Director, Administrator, CEO or CFO must sign as 'Authorized Signature'. A stamped provider's signature or office manager's signature is not acceptable. An <u>original</u> signature is required.

Upon receipt of all necessary information, a determination will be made regarding your qualifications as a provider under the South Dakota Medical Assistance Program. When determination has been made a provider number will be assigned to you and a copy of the agreement returned to you for your files.
Thank you in advance for your assistance in this matter.